New Era in Healthcare: Exploring Possibilities for MPL/HPL

AND

Five Myths About Trials
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In the past several years, there has been an unprecedented level of change in healthcare systems around the world. In the U.S., we have seen the emergence of accountable-care organizations, bundled payments for complex procedures, and increasing employment of formerly independent-practice physicians, to name a few.

While there are obvious differences among the various nations’ healthcare systems, there are also a surprising number of similarities. For example, there is a common pattern in many countries of migration of physicians from independent practice into hospitals.

Through it all, PIAA members both in the states and abroad continue to steer a steady course, remaining financially stable and reliable year after year.

How have they done it? A common characteristic among PIAA members that has helped them to remain relevant is adaptability. It is now more important than ever to maintain the strong skills that form the foundational functions of underwriting, claims management, and financial accountability while also demonstrating the flexibility to evolve, as new, or more potent, forces emerge that compel MPL/HPL insurers to recalibrate some aspects of the duties they perform to protect and defend insureds.

This issue of Inside Medical Liability explores some fundamental alterations in the marketplace—and what MPL/HPL insurers may need to consider to successfully transition into a new era. The new configuration of the healthcare market has in fact opened up new opportunities for growth. Our cover story, “Diversification in the Medical Professional Liability Market,” examines these opportunities to take advantage of change—and sets forth some thought-provoking ideas for different approaches for a successful future.

There are many areas where the knowledge base and expertise of MPL/HPL organizations can be invaluable. It’s important for MPL/HPL insurers to take a careful look around to identify all of the needs of their current and future customers.

This same advice applies to PIAA as well. Like every membership association, PIAA periodically re-examines its strategic direction and initiatives, thanks to the survey participation of many members in the U.S. and around the world. The Board of Directors is currently leading the effort to ensure your association is focused on the key feedback that you have provided. We look forward to sharing with you the outcome of these important discussions. PIAA is committed to supporting its members, in tangible ways, in whatever ventures they embark upon.

This issue also includes an interview with Robert Wachter, MD, the Keynote Speaker at the 2017 PIAA Medical Liability Conference, May 17-19, at The Broadmoor in Colorado Springs, Colorado. Named by Modern Healthcare as one of the 50 most influential physician executives in the U.S. for 2016, Dr. Wachter is no stranger to change and makes some interesting projections for the future.

We are especially excited to be anticipating another meeting in 2017, October 4-6 in London, the PIAA International Conference. Its theme has significance for healthcare systems worldwide: “Change & Disruption: Strategies for Managing the Evolution of Medical Liability.” Sagacious insights about this event are provided in an “International Perspective” Q&A with Dr. Christine Tomkinds, Chief Executive, The Medical Defence Union, and PIAA Board member, and Simon Kayll, Chief Executive of the Medical Protection Society. Their organizations, along with the PIAA International Conference Planning Committee, are playing a key role in the planning and logistics for the conference.

We very much hope that you will join us for both conferences. You will learn a great deal, expand your horizons, and share new strategies with colleagues, and new friends, from all over the world. Like the articles in Inside Medical Liability, these PIAA-sponsored meetings will help you be fully prepared for tomorrow—whatever that might bring.
"But in the interim, the challenge to MPL insurers will be to recognize their customers' changing needs and provide solutions for them, while at the same time considering whether to expand into complementary lines of insurance."

—Cover story
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EVENTS & CALENDAR

■ 2017 Leadership Camp—Keynote Session
Resilience in Medical Systems and the Impact on Patient Safety
Wednesday, May 17, 9:15–10:15 a.m.
Richard J. Cook, MD, research scientist and Clinical Professor of Anesthesiology, The Ohio State University

Despite efforts to enhance patient safety, the rate of accidents in medicine has in fact changed very little over 25 years. Advances in technique and capacity appear to have been focused, instead, on expanding the scope of care and increases in productivity. The surprising thing for many in practice is not that there are so many accidents—it’s that there are so few! Why is this so? What are the consequences of diminishing the importance of securing resilience in the system in pursuit of other goals? How can the constant tension between “safety” and “production” be resolved? Jens Rasmussen’s model of system safety provides a means for capturing the factors involved in this tension and thereby describing the situation that confronts practitioners—in medicine and in other fields. Dr. Cook will use this model to set the stage for an examination of what is involved in engendering resilience and, conversely, the factors that lead to its erosion.

■ 2017 Medical Liability Conference—Luncheon Session
Survival—The Aron Ralston Story
Friday, May 19, Noon–2:00 p.m.
Aron Ralston, fearless adventurer and subject of the film, “127 Hours”

Aron Ralston’s extraordinary life-altering story of survival, as told in the New York Times bestseller, Between a Rock and a Hard Place and the film, “127 Hours,” starring James Franco, captured headlines around the world when he accomplished the astonishing feat of freeing himself from entrapment between two boulders in a remote canyon—by severing his own arm. In 2003, Ralston, an experienced climber, was descending alone down a remote Utah canyon wall when an 800-pound boulder broke loose, crushing his right hand and pinning him against the canyon wall. After nearly five days without water, no means of communication or absent any hope of escape, Ralston harnessed his determination and will to live. Using a pocket knife to sever his arm below the elbow, he then rappelled a 65-foot cliff out of the canyon and trekked 7 miles to find rescuers.

With an unforgettable story of an ordinary man pushed to extraordinary limits, Ralston will take you on a riveting journey in which courage, perseverance, and the human spirit defy what seems like an inevitable outcome. His powerful narrative will encourage you to recognize your inner potential and to appreciate and harness your relationships.
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It’s a Rich Tradition Hereabouts: Annual ‘Judicial Hellhole’ Awards

Since 2002, the American Tort Reform Foundation’s (ATRF) “Judicial Hellholes” program has zeroed in on problems in jurisdictions where the judges in civil cases systematically apply laws and court procedures in a way that’s unfair and unbalanced—generally to the disadvantage of defendants. But where does the information come from? From the American Tort Reform Association’s (ATRA’s) real-time monitoring of Judicial Hellholes activity, year-round, and from feedback garnered from ATRA members and other firsthand sources.

And now, let’s unveil this year’s lineup of proud winners.

1. St. Louis, Missouri. The City of St. Louis is a magnet for product liability lawsuits and consumer class actions. The local trial court hosted three gigantic verdicts this year, totaling $197 million. How does this happen? Among other factors, the state has a weak venue law coupled with a lenient standard for expert testimony that allows “junk science.”

2. State of California. By enacting more than 800 new laws every year, legislators and the governor make it all but impossible for California residents and businesses to stay current and thus avoid being targeted by the nearly 1 million new lawsuits filed there annually.

3. New York City asbestos litigation. Nothing new here: Judges persist in combining multiple lawsuits into a single trial, blending evidence, confusing jurors, and driving up awards.

4. The State of Florida and South Florida. Here, we find another long-running tradition of liability-expanding rulings and decisions that rewrite and invalidate any laws that don’t seem to fit the current policy tastes of a majority of the court’s members.

5. The State of New Jersey. The Garden State’s high court has apparently declared war on the use of arbitration as an alternative to lawsuits and issued liability-expanding rulings.

6-9. These are the also-rans, at this point, but there’s every hope that, with resolute effort, they could well advance to the top five by late 2017: Cook, Madison, and Clair counties, Illinois; Louisiana; Newport News, Virginia; and Hidalgo County, Texas.

As in years prior, Observer confesses to some genuine discomfort with this shamelessly truncated “one-through-nine” take on the classic “top 10 list.”

Source: American Tort Reform Association, January 6, 2017

After 23 Years of Litigation, a Settlement in a Hospital Death

Is this a record? Perhaps. All we know, without paying the website’s requisite “two tokens” for full details, is that the legal battle has concerned the 1993 death of a Slovenian boy, Gregor Silih. The parents claim the death was caused by malpractice. The state, the defendant in the case, claimed otherwise.

As one element in the settlement, the state has promised to put in place “systemic solutions for establishing medical malpractice accountability.” Easier said than done, we’d say.

Source: STA, December 13, 2016
Now, it’s time to move on to the literature section of the column. Steve Clark, with more than four decades of MPL law under his belt, has just published *Justice Is for the Deserving: A Kristen Kerry Novel*. Noting the insatiable appetite among Americans for entertainment featuring all things legal, the press release on the book asserts that “it is sure to put court fans in a tizzy.”

Here, Kristen “puts her career on the line, and her life in jeopardy, to uncover the truth about a child’s death.” Kristen has the pretty much standard collection of adjectives to describe her: “strong, fearless, athletic, and attractive.” But, a true child of the Age of Dr. Phil, she is also “the child of manipulative and neurotic alcoholic parents.”

The payoff for readers? Beyond the plot and the lively legal banter, the novel purportedly “reveals just as much about those that practice and defend the law as it does about the legal system.” Well, what more could you ask for?

That was the headline of an item in the Fourth Quarter 2015 “Observer.” With our fingers on the pulse of all that matters, we’ve managed to locate the press release announcing “Three Students Win a Total of $2,500 in Baker & Gilchrist Scholarship Contest,” December 21, 2016.

But somehow, the winners seem to have submitted essays—not videos. And $2,500 for the total amount awarded? Kind of skimpy, one might think, for three people.

Anyway, here is what brought home the first-place award, says the release:

“Mary Graham, Texas A&M. She won $1,250 for her essay on improving health literacy rates among patients. She hopes to work internationally to develop and evaluate health literacy rates among patients.”

And, we trust, also promote peace and love among all peoples, in every nation. But it would be interesting to know how much publicity this contest actually generated. If it’s much more than zero, the $2,500 spent on it is a pretty savvy investment.

Source: Digital Journal, December 21, 2016

The source article is titled: “Hospital Insists It Was Malpractice; Patient Disagrees.” On February 23, 2012, patient Manuel Nava fell and injured his clavicle and patella when a hospital gurney tipped over. The hospital insisted that the patient was injured by professional negligence, but the patient vehemently disagreed. The argument went all the way to the state court of appeals.

The explanation is immediately clear to medical professional liability (MPL) defense attorneys: the plaintiff wanted the more relaxed rules of general negligence law (while the hospital wanted the protection of the state’s MICRA Act). Filing the claim in 2014, plaintiff Nava needed the two-year window governing premises liability claims for personal injury, instead of the one-year window that applies to MPL suits.

Bottom line: Nava prevailed.

Source: Digital Journal, December 21, 2016

It’s Not a Typo. Honest.

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Source: Digital Journal, December 21, 2016

Source: JG Supra, January 27, 2017

Source: SAT PR News (Warsaw), December 14, 2016

It’s Not a Typo. Honest.
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Are you ready?

Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Dillon, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Vicki Smith, Brad Stewart and James Johnson
PIAA Data Sharing Project

Specialty Snapshot: Otorhinolaryngology

A review of PIAA Data Sharing Project claims and lawsuits closed between 2011 and 2015 showed Otorhinolaryngology with the highest paid-closed ratio among medical specialties (excluding dental).

For more detailed information, see the PIAA MPL Specialty Specific Series for Otorhinolaryngology or contact P. Divya Parikh at dparikh@piaa.us.

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Correction: The Fourth Quarter 2016 DSP Snapshot (Opioid Claims and Related Narcotics) incorrectly noted the paid/closed ratio difference as 24% instead of 24 pp (percentage points). Specifically, the paid/closed ratio nearly tripled from 12.7% to 36.3%.
The following is taken from the Bureau of Labor Statistics report on employment prospects in various occupations:

Employment of insurance underwriters is projected to decline 11 percent from 2014 to 2024. Automated underwriting software allows workers to process applications more quickly than before, reducing the need for underwriters. As this technology improves, more underwriting decisions can be made automatically. However, there still will be a need for underwriters to evaluate automated recommendations, particularly in complex or specific fields, such as marine insurance.

This projection is for all lines of insurance—but will this happen in MPL?

Note that 11% is not a huge change if it is achieved incrementally over the next eight years, but it is certainly big enough that MPL entities will feel its impact.

What are the forces that may lead to changes in MPL underwriting?

Fewer independent physicians
One change in the MPL market has nothing to do with automation.

Here are Accenture’s numbers for independent physicians as a percentage of total physicians, indicating the trend wherein doctors become employees of hospitals. Accenture predicts that, by the end of 2016, the number of independent physicians will drop to 33% (Table 1).

When doctors transition to self-insured hospitals, the credentialing process replaces underwriting. And when hospitals look for insurance in the open market, the underwriting process for its physician staff is simpler, and on a more aggregated basis, than if those doctors were independent—for example, by using full-time equivalents to represent them.

Business culture and practices
MPL is not called a “specialty line” for nothing: this term implies a more complex underwriting process that is less amenable to automation.

Table 1. Independent versus Employed Physicians

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of U.S. Physicians</th>
<th>% Who Are Independent</th>
<th>Number of Independent Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>683,000</td>
<td>57%</td>
<td>389,000</td>
</tr>
<tr>
<td>2005</td>
<td>723,000</td>
<td>49%</td>
<td>354,000</td>
</tr>
<tr>
<td>2013</td>
<td>794,000</td>
<td>37%</td>
<td>294,000</td>
</tr>
<tr>
<td>2016 (estimate)</td>
<td>821,000</td>
<td>33%</td>
<td>271,000</td>
</tr>
</tbody>
</table>

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adding nine more questions to the insurance application really make a difference?

Another factor contributing to a more streamlined approach to business is the notion that simplicity allows for a more easily intelligible insurance product and better service—and the ability to compete on quality of service has never been as front of mind as it is today.

Technology and automation

If the corporate culture is in fact amenable to change now, technology stands ready to support this new approach in a way that was impossible only a few years ago.

Here are four examples of what can be done:

■ Business acquisition processing
The business acquisition workflow can look something like this:

- Applications can be filled out by the user online, with electronic signatures.
- Underwriting rules can be automated, so that applications that fall outside of guidelines can be flagged as exceptions that need to be handled by the underwriter, who can then review the application data online. The underwriter can also be alerted if the applicant has had prior dealings with the company.
- Any follow-up actions that are needed can be handled electronically. Communication between underwriter and insured can be done via e-mail.
- The data can be moved through a policy administration system without the need for reentering any of it.
- A quote (full or indication) can be generated and sent out electronically.
- Finally, if the business is accepted, the creation of the policy record can be accomplished simply by accepting the quote.

In all of this processing, not a single element of data will have to be reentered, the system can control the workflow and the status of each application and quote, and the underwriter need only review those applications that are selected by the system as exceptions. All in all, a well-designed straight-through processing system with these features can dramatically enhance underwriter productivity, timeliness, and accuracy.

■ Automating Renewals
All renewals “are not created equal,” but too often, they are all processed via the same labor-intensive workflow. Systems can be configured to evaluate each renewal and decide based on criteria what extent of “underwriting” is needed. A policy for an individual in a low-risk specialty with no claims for the past five years could be renewed automatically; a more complex policy would be referred to the underwriter. In all cases in which a renewal application/validation is required (again determined by pre-established criteria), it can be generated automatically by the system and e-mailed to the insured. The completed document can then be analyzed according to automated business rules for changes—those that can be applied to the policy without intervention (for example, a change to the deductible) and those that will require underwriter review (for example, a request to increase policy limits).

■ Predictive analytics
The use of predictive analytics to evaluate the insured’s propensity for a loss is a subject unto itself. This technique has not been widely adopted so far, but its time will come.

With automated “scoring” of risks, the system alerts underwriters about new business applications and renewals that need their attention, to the benefit of efficiency and productivity. And because the compilation of attributes that are evaluated and weighted by predictive analytics exceeds the catchment of traditional data that underwriters rely on, there is a potential benefit to loss experience.

■ Web portals
The idea of offering 24/7 service to the client has to be an appealing notion.

Most companies have some form of Web presence today, but in many cases, they have a long way to go in achieving much in the way of functionality. Some of the limitations with portals are driven by concerns about security, by the idea that they distance the insured from the company, and that if the site offers too much information and too many functions, the occasional user may become confused, or conversely, if there is inadequate information, that may give rise to unanswered questions. These aspects need to be addressed, and they all can be, through proper design of the site.

MPL companies should note that security concerns have not stopped the wide adoption of e-commerce by banks, brokerages, retail merchants, and countless others.

Using the application of business rules to functions that are performed by the insured via the portal allows the system to automatically alert the underwriter when some exception condition is found. There are so many scenarios where this can be used, but here’s one example: If an address change is processed, the system should be able to determine if a premium adjustment is needed because the insured has moved to a different rating territory, and it can then alert the underwriter about it.

How do Web portals make underwriters more productive? Easy. They let the insured take care of many of the routine transactions without any attention from the underwriter. Also, the information presented on the Web portal should answer many of the insured’s more common questions, thereby reducing both phone call volume and mailing costs. Using the Web portal, the insured can print out certificates of insurance, credentialing letters, loss runs, and so on, without any required action by the company.

A final thought. Increasing productivity is obviously linked directly to a desire to save on expenses. But the measures that are discussed here can also have a positive effect on one or more of these:

- Quality and accuracy
- Underwriting results
- Customer service.

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Here is the customer in your organizational chart? Is it at the top? The center? Does the customer surround your organization like a nebulous cloud? Or is the customer assigned to a specific role or function to be managed? If yours is like most organizations—let alone insurers—the customer is not actually on the organizational map at all. Of course, some will argue that the customer “is at the heart of what we do,” but when you start really peeling back the layers of an organization, you find that ownership of the customer experience is not something written into many job descriptions or even considered when doing the annual performance review.

Why is knowing where the customer is located on your organizational map important? There are both right- and left-brained reasons. For those who think in terms of relationships, business author and circuit-speaker Tom Peters wrote in his book *The Pursuit of Wow!* that 64% of people stopped doing business with a company because they felt that the employees of that company were simply indifferent to them. In other words, nearly two-thirds of customers went someplace else because they didn’t feel cared about.

For those who think in terms of spreadsheets, let’s imagine the lifetime top-line revenue value of an average insurance risk to be worth $150,000 ($15,000 x 10 years). If you have 5,000 risks, that’s $750 million over 10 years, but if Tom Peters is right, nearly $480 million of that is at risk of leaving your company because it doesn’t have an organizational focus on the customer. Of course, you can play with these numbers and add in different averages or lengthen/shorten the amount of time, even discount the value based on loss experience. But, don’t forget to add in all the funding it took to acquire that risk and that additional funding is needed to acquire new accounts and replace the lost revenue.

But irrespective of right- or left-brained approaches, the point is this: Without a focused approach to putting the customer at the center of your business, your potential for unnecessarily lost revenue, reputation hits, and declining market share is astounding.

Peter Drucker once said the only purpose of a business is to create and keep customers. As you unpack all that his statement means, it’s easy to begin to focus on the things to do and lose your focus on the customer. This shouldn’t be surprising to anyone. Many businesses today make it very difficult for customers to do business with them. In pursuit of organizational effectiveness and streamlining operations to seek out more profitability, policies and administrative barriers are created that place hurdles for customers to overcome. And, in today’s warp-speed business environment where consumer choice and empowerment are at an all-time high, many customers simply won’t waste their time in dealing with the hassle.

But there are ways your organization can change the tide of indifference to a customer centricism that creates loyal fans.

Words matter—what’s your pivot point?

Here is a quick test. Go to your organization’s website and see where the “About Us” tab is located in the site’s navigation. Is it first in the lineup of tabs? If so, it’s possible that you’re really good at talking about yourself first when, instead, you have an opportunity here to address your customers’ needs first. When you review your organizational materials, policies, products, and even how you conduct your meetings, does the language you use start with words like us, our, we? If so, then the challenge for your organization is to begin to think in terms of them and they. If you think in terms of “Our first priority is to…” what would happen if you changed the pivot point to be “Our members’ first priority is to…”? By making these simple but profound changes in the way you talk, think, and act, you can replace the orientation of organizational-centricism to customer-centricism.

I once heard a story about the Mayo Clinic, and how they start each meeting in their

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David Kinard, MEd, PCM, is Senior Vice President, Business Development, Physicians Insurance A Mutual Company.
organization with a patient story. Whoever is leading the meeting will share a story, or open up the floor for someone else to share a story—keeping their focus on the patients they serve, their challenges and successes, their fears and joys. Whether it’s an apocryphal tale or true, the lesson is clear about what we need to do to train our teams and transform our culture to focus first on our customers.

Purpose and values—organizational genetics
When you read your organization’s statements on its purpose and value, how customer-centric are they? Do these statements talk about your organization, or are they focused on bringing value to the customers, on serving their needs, on adding in some positive way to their experience? (It is an important side note to recognize that many of today’s leading organizations also view their employees as customers—perhaps some of your statements might reflect how you engage with each other, too.)

Some of today’s leading organizations created customer-centricism at the genetic level, as expressed in their mission statements. Whole Foods Market’s mission reads: “Our deepest purpose as an organization is helping support the health, well-being, and healing of both people […] and the planet.” The mission of the American Red Cross begins “To prevent and alleviate human suffering….” And the first part of the mission for Doctors Without Borders is, “To help people worldwide where the need is greatest…”

Walk a mile in their shoes—customer journey maps
If you want to deepen your organization’s understanding of its customers, one of the best ways to accomplish this is to create customer experience maps. According to Forrester, author of dozens of thought-leading articles and white papers on this topic, a customer journey map is a “document that visually illustrates customers’ processes, needs, and perceptions throughout their relationships with a company.”

Forrester also notes that executives are adapting to include more customer-centric modeling in their companies, seeing it as critical to their business’s ability to become the customer experience leader in their industry.

If you are starting out for the first time in creating customer-experience or journey maps, begin with one customer type, for instance, solo physicians buying a policy via a broker. As you identify the various steps the physician takes, be sure to capture her moments of truth: those places where decisions get made to continue with the process or your organization, or bail and go somewhere else. Place special importance on the moments where you create hurdles for her and see if you can alleviate that burden for her. And try to replicate the processes that you have created for her that add value to her experience.

The great American poet and civil rights leader Maya Angelou once remarked, “I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.” When thinking about where the customer is located within your organizational chart, is it a place where they feel good or bad—or just indifference from your company? Perhaps, with a few simple steps, you can begin to noticeably improve their experience, as you create a truly customer-centric organization.

For related information, see www.phyins.com.

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The unexpected election results of last November have left many people scratching their heads about what to expect in federal healthcare policy in the coming years. While the Trump Administration and congressional Republicans have been clear about their intent to repeal the Affordable Care Act (ACA) (efforts that are just getting underway as of this writing), many have been confused about what will come next. Political pundits and journalists have spent vast amounts of time and energy hypothesizing about what legislation to replace the ACA (assuming it is repealed) will look like. Will it be shaped by past legislation supported by Trump’s nominee for Secretary of the Department of Health and Human Services, Rep. Tom Price? Will it be guided by the most vocal ACA opponents in the House, the House Freedom Caucus? Despite some claims, it will likely be neither of these. If you want to see what the replacement side of “repeal and replace” will look like, you’d be wise to begin by looking past the hype.

Overview
Last year, Speaker of the House Paul Ryan (R-WI) called on his fellow Republicans to develop a new plan for guiding their agenda in the years ahead. Rather than persisting with the some-times-disjointed attacks on current policy, the Speaker assembled working groups comprised of committee leaders and key players on specific policy areas to develop a positive agenda for what the party would do going forward. The resulting compendium was titled “A Better Way,” and represented what Speaker Ryan referred to as “a full slate of ideas to address some of the biggest challenges of our time.”

“A Better Way” focuses on six policy areas, including healthcare. Most important, for our purposes, one of the many areas within healthcare that it addresses is medical/healthcare professional liability (MPL/HPL) reform. The reforms noted in the document include the following: caps on damages; limits on attorney fees; loser pays all court costs; reform of the joint and several liability rule; reform of the collateral source rule; statutes of limitations; use of practice guidelines; health courts; medical review panels; and new standards of evidence. Given that these provisions were developed and supported by significant individuals in the Republican leadership, these are the most likely issues that will be included in the MPL/HPL reform provision of new healthcare legislation.

Federal reforms
The MPL/HPL portion of A Better Way is explicit about the need for caps on damages, stating, “We know that comprehensive medical liability reform that includes caps on non-economic damages will improve patients’ access to quality care while reducing the overall cost of health care in America.” The question then must be, what level of cap would congressional leaders embrace? Based on past congressional
votes, and on PIAA’s discussions with the leadership, it is likely that the “flexi-cap” from the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act would be the preferred option. Under this concept, a federal cap of $250,000 on non-economic damages would be established, but states would be allowed to preempt the federal cap by enacting their own cap, regardless of the amount. Thus, all states that already have a cap in place would get to retain it, irrespective of whether it’s $250,000 or $750,000 or whether it applies to non-economic damages or total damages. Any state with no cap in place would then be subject to the federal $250,000 cap, until such time as it enacted its own cap of any dollar value.

The other federal reform embraced in the document is limitations on attorney fees. Again, the most obvious place to look for guidance on what Congress would do with this reform is the HEALTH Act: It has passed in the House many times, and its limits on attorney fees have been included in other tort reform bills. In this case, the federal language will likely mirror that of California’s MICRA statute, with a sliding-scale limit on attorney fees of 40% of the first $50,000 of the award/settlement; 33.3% of the next $50,000; 25% of the next $500,000; and 15% of any amount in excess of $600,000.

State reforms
While the federal reform proposals will presumably get most of the attention, “A Better Way” actually focuses much of its content on state-level reforms. It reads, “We will also encourage states to continue to be laboratories of innovation to find the best means by which to reduce frivolous lawsuits and the practice of defensive medicine.” While details in the text were not plentiful, we can reasonably assume that such reforms will be encouraged through demonstration grants or incentive payments provided as an inducement for state adoption. The document specifically lists the following proposals, and I’ve taken the liberty of describing what I think they would serve as a likely model. Its limits, three years from injury or one year from time of discovery, have been standard language in many congressional bills for years.

- **Loser pays.** This reform would state that the losing side in an MPL/HPL suit would pay all the associated legal expenses, including the other side’s attorney fees. While long popular with tort reform advocates, it would seem to have value only as a possible deterrent to potential lawsuits.

PIAA international members with experience in these systems say that the bad publicity engendered by attempts to secure funds from a person who has suffered an adverse outcome (not the result of medical negligence), combined with the fact that it is unlikely that the plaintiff has sufficient resources to pay the defense costs, make this an impractical option.

- **Proportional liability.** Most likely, this would mean several, and not joint, liability: an individual would be responsible only for the proportion of damages for which he is actually responsible.

- **Collateral-source-rule reform.** There have been two distinct provisions in this category of reform in recent federal bills. One is as an evidentiary rule that lets juries hear that outside sources have paid for some or all of the patient’s damages. The other is a mandatory offset: the amount of funds provided by a collateral source (e.g., health insurance) is deducted from a final award amount. States may be given the option of trying either alternative.

- **Standards of evidence.** Again, California would serve as a likely model. Its limits, three years from injury or one year from time of discovery, have been standard language in many states to them.

- **Medical review panels.** Several states already test the idea of using panels of medical experts to screen MPL claims before they go to court as a way of discouraging meritless claims. States have had varying degrees of success with these panels, so it’s not clear what shape this approach might take in federal legislation.

- **Safe harbors/practice guidelines.** One of the newer reforms to garner significant attention, the idea of using recognized practice guidelines as an affirmative defense against a negligence claim, has bipartisan support. Of course, the personal injury bar only likes it if failure to follow a guideline is also deemed evidence of negligence, but this approach may not appeal to GOP lawmakers.

- **Health courts.** One of the reforms supported by Cong. Price, it would likely focus on dedicated courts that use specially trained judges who have medical expertise to accelerate the litigation process.

What’s next?
Will all, or any, of these reforms actually be included in an ACA replacement bill? That’s not easy to say. Many will certainly be written into early drafts, but those drafts will likely look a lot like the outline in A Better Way. The legislative process can be fickle, however, and it is likely that, as this legislation moves forward, a significant amount of negotiating and horse trading will occur in an effort to secure passage of the bill. Some MPL/HPL provisions may have to be eliminated to attract Democratic votes, especially in the Senate, where 60 votes will be needed for passage. Still others may be removed to appease states’ rights Republicans who, in recent years, have opposed federal reforms of any kind. On the other hand, a comprehensive healthcare bill may find some, on either side of the aisle, willing to accept reforms that they would not normally support, to secure other healthcare-related policies that truly matter to them.
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In a medical professional liability (MPL) action in New York State, a plaintiff must sufficiently establish two elements. Initially, the plaintiff needs to prove that the defendant was negligent in the care or treatment provided. The second element is a demonstration that the negligent care or treatment proximately caused the injury to the plaintiff. Consequently, even though a plaintiff may establish a physician's negligent medical treatment, there is no finding of MPL in instances where the plaintiff fails to show that the negligence was a proximate cause of the injury.

In a recent decision by the New York State Court of Appeals, the highest court in the state, the court examined the issue of proximate cause with regard to treatment by a psychiatrist of a patient who ultimately committed suicide. Although the case involved two psychiatrists who treated the patient independently, and the jury found that both psychiatrists were negligent, the jury found that only one of the psychiatrist's treatments proximately caused the patient's suicide.

**Underlying facts**

Mazella v. Beals

Mazella v. Beals is an MPL and wrongful death action in which the plaintiff, the decedent’s wife, alleged that the defendant physicians were negligent in their care and treatment of the decedent, in that they failed to properly prescribe and monitor the decedent's medications and failed to adequately diagnose the decedent's worsening condition.

Dr. William Beals (hereinafter “the defendant”) began treating the decedent in October 1993, when he diagnosed the decedent with major depression, obsessive-compulsive disorder (OCD), and generalized anxiety disorder. The decedent was prescribed Paxil, an antidepressant. Shortly after April 1994, the defendant tapered the decedent off of the Paxil and then discontinued the medication about one month later.

The next time the decedent contacted the defendant was in April 1998, after an episode of depression. At this time, the defendant agreed with the decedent's family physician that the decedent should be placed on Ativan, an antianxiety drug, and 40 mg of Paxil. Within a few weeks, the decedent showed signs of improvement, and the defendant reduced, and then discontinued, the Ativan. The defendant also reduced the Paxil to 20 mg.

Thereafter, the defendant went on to refill the decedent's Paxil by telephone or facsimile for a period of 10 years, without ever seeing or examining him. On August 9, 2009, the decedent called the defendant with complaints of anxiety, increased obsessive thoughts, and difficulty sleeping. The defendant was away on vacation at the time, but
instructed the decedent by telephone to double his dosage of Paxil, to 40 mg. The defendant also prescribed Zyprexa for the anxiety and sleep problems. The following day, August 10, 2009, the plaintiff and decedent called the defendant, complaining that the decedent was pale, nauseous, lightheaded, and did not feel well. The defendant instructed the decedent to double the Zyprexa dosage and said that he would call the decedent the next day.

On August 11, 2009, the plaintiff felt that the decedent’s condition was worsening, and she took him to the emergency room, where the decedent was medically cleared and then transferred to the hospital’s Community Psychiatric Emergency Program (CPEP) for overnight observation. The decedent was complaining of suicidal ideations, difficulty sleeping and controlling his thoughts, and feeling as if his body was on fire on the inside. The decedent was taken off Zyprexa and given Ativan. He was discharged the following day, with instructions to discontinue the Zyprexa, take Klonopin, and reduce his Paxil dosage to 30 mg.

The decedent appeared stable for the next five days, but then visited the defendant psychiatrist on August 17, 2009. The plaintiff and defendant presented very different accounts of this visit at trial, but both accounts state that the defendant told the decedent to go to CPEP, and it was undisputed that the decedent did, in fact, go to CPEP later that day. The decedent initially declined indecedent care, but he did complain of being suicidal and was therefore placed on 15-minute safety checks for the next 27 hours, and his access to “lethal means of suicide” was restricted. The following day, August 18, the decedent’s medications were adjusted and he was discharged, despite having complained of feeling hopeless and worthless, and repeating his assertion that he would kill himself.

On August 18 the decedent had a difficult and restless night, and so he returned to CPEP on August 19 where he was given Ativan and placed on 15-minute safety checks for about 12 hours. Then, on the evening of the August 19, the decedent was transferred to the psychiatric unit of one of the local hospitals.

On August 20, the decedent was seen by Dr. Mashinic, who adjusted his medications and placed him on increased dosages of Paxil, Klonopin, Zyprexa, Ativan, and one other antipsychotic drug. That night, after Dr. Mashinic discontinued the one-on-one suicide watch, the decedent attempted suicide by tying the belt of his hospital gown around his neck. Dr. Mashinic reinstated the suicide watch, again changed the decedent’s medications by replacing Paxil with another antidepressant and adding Risperdal. The decedent remained in the hospital for about a week, during which time doctors at the hospital adjusted his medications, but he continued to complain of anxiety, depression, and increased repulsive thoughts of a sexual nature.

The decedent was discharged on August 27 and referred to a center for outdecedent psychiatric care. The center had a three-part screening and intake process, which the decedent began on September 3, 2009, by meeting with a social worker. At that time, the decedent complained of suicidal and obsessive sexual thoughts. He had his second intake visit on September 9 and met with a psy-

In New York State, a defendant’s negligence qualifies as a proximate cause where it is “a substantial cause of the events which produced the injury.”

However, they also determined that Dr. Beals’ negligence was a proximate cause of the decedent’s suicide, but that Dr. Mashinic’s negligence was not.
mate cause of an injury.”

In Mazella, defense counsel for Dr. Beals argued that the indecedent treatment at the hospital and the treatment by other medical professionals after Dr. Beals last saw the decedent were intervening and superseding events that severed any causal connection between Dr. Beals’ conduct and the decedent’s suicide. Defense counsel further argued that the suicide was too far removed from Dr. Beals’ treatment of the decedent for that treatment to be considered a proximate cause of the suicide. The Court of Appeals denied both of these arguments and held that Dr. Beals’ treatment of the decedent was a proximate cause of the suicide.

In reaching the conclusion that Dr. Beals’ treatment was a proximate cause, part of the court’s reasoning was based on its determination of the foreseeability of the subsequent treatment. Dr. Beals had conceded at trial that the last time he saw the decedent, the decedent’s behavior was unusual and, for the first time, the decedent was unable to assure Dr. Beals that he was able to control his suicidal thoughts. The court further noted that the jury could have credited the plaintiff’s version of the August 17 visit with Dr. Beals, in which the plaintiff testified that Dr. Beals was highly inappropriate and that the decedent had left that visit a “crumbling mess.” The court therefore concluded that the jury could have concluded that it was foreseeable that the decedent would seek treatment by others and that the treatment could potentially be lacking. Based on these circumstances, the court did not feel that the subsequent treatment was “of such an extraordinary nature or so attenuated defendant’s negligence from the ultimate injury that responsibility for the injury may not be reasonably attributed to the defendant.” In essence, the court found that the treatment by Dr. Beals had created the condition and circumstances leading to the subsequent treatment and that Dr. Beals could have foreseen that subsequent treatment based on his own care and treatment and the condition of the decedent.

**Takeaways**

In this particular case, defense counsel was in a difficult position in determining how to defend the case, and the issue of proximate cause was paramount. The reason for this was that the New York State Office of Professional Medical Conduct had charged Dr. Beals with negligence in regard to 13 decedents. He did not sign a consent order admitting to that negligence, for 12 of the decedents. He did not sign a consent order with regard to the decedent in the Mazella case. The trial court, however, allowed the consent order for the other 12 decedents to be admitted at trial, and Dr. Beals therefore conceded that his failure to monitor and meet with the decedent in this case, for a period of 10 years, was negligent.

With negligence admitted, there was no choice but to proceed with an argument that the negligence was not a proximate cause of the suicide. Although the Court of Appeals found the evidence against Dr. Beals sufficient to establish proximate cause, the court also found that it was erroneous for the trial court to have allowed the evidence of the consent order and discussion of Dr. Beals’ failure to monitor 12 other decedents and, based on that finding, ordered a new trial.

Providers need to be cognizant of the importance of proper monitoring and periodic examinations and meetings with their patients over the course of treatment relationships. In this particular case, it is likely that the failure to monitor the decedent outweighed, in the minds of the jurors, any of the subsequent treatment that the decedent received and placed responsibility for the outcome squarely on Dr. Beals.

It is also important for providers to be aware that treatment, and possible negligence, by subsequent treating providers does not necessarily absolve the provider of liability for negligence. In the case of Dr. Beals, the court relied on its determination that it was foreseeable to Dr. Beals that, based on his own treatment and the known condition of the decedent, that the decedent might seek additional treatment from other providers. Based on this, Dr. Beals could still be liable for the decedent’s eventual suicide, despite the approximate month that had passed and the various other providers that had become involved in the decedent’s care.

**References**

1. 37 N.Y.S.3d 46.
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Less attractive market fundamentals

PL writers emerged from a major crisis period at the beginning of the century and generated a decade of annual underwriting profits from 2006-2015. This market renaissance was fueled by sharp premium rate increases and re-underwriting, benefits in claims experience from tort reforms enacted in a number of states, and the removal of inefficient capacity via market withdrawals and insolvencies.

While the legislative reform measures passed in the last decade largely remain in place, and national multi-line insurers have not re-entered the market in substantive numbers, the underwriting environment has changed significantly in recent years, because of major changes in the overall healthcare market.

Changes in the delivery of medicine, in part caused by healthcare providers’ response to the implementation of the Affordable Care Act, have led to a shift in physician employment; now, much of it is within hospitals and larger medical groups, thereby altering the way in which MPL coverage is purchased. Larger groups are more likely to self-insure and utilize captives and other alternative risk products.

Declining premiums and underwriting performance

The gradual shrinking of the underwriting exposure base has led to
declining written premium volume and price competition. MPL premiums had decreased by approximately 23% by 2015, from a historical peak of $10.4 billion in 2006 (Figure 1).

Segment underwriting performance has eroded in recent years as well (Figure 2). The MPL industry combined ratio was below 90% from 2007-2011, but has risen significantly in recent years to 98% in 2015; it will likely move into an underwriting-loss position in 2016 or 2017.

Several factors are driving this deterioration. Reported accident-year loss ratios have increased significantly (Figure 3), reflecting weaker pricing. The MPL industry expense ratio has risen by approximately 7 points in the last decade to approximately 25%, as expense levels have not fallen commensurately with premiums.

More recently, the trend toward favorable reserve development experience has shown signs of slowing. For the last decade, MPL has demonstrably had the most conservative loss reserves of any property/casualty product line: Annual favorable reserve development has averaged more than 20% of calendar-year earned premiums.

Total reserve development declined in 2015 and is likely to have posted further declines in 2016 and afterward. MPL industry reserves remain significantly redundant, but recent accident years are exhibiting significantly less redundancy, as loss experience emerges relative to that of prior years. Future reserve experience will also hinge on whether MPL claims and litigation trends continue to exhibit the general stability of recent years.

**Capital strength and future deployment questions**

The capital strength of the MPL specialists greatly improved over the last decade, as strong operating results generated growth in surplus, while premium exposures and reserve levels have tapered off recently.

Reviewing a group of 36 MPL specialists reveals that from year end 2005 to 2015, policyholders’ surplus grew by nearly 200%, to more than $14 billion. Aggregate operating leverage (net premiums written / policyholders’ surplus; Figure 4) for this group fell to 0.3x in 2015 from 0.9x in 2005. The median risk-based capital ratio for this group improved to 615% of the company action level, from its previous ratio, in 2005, of 277%.

If the operating leverage ratio were to double, to 0.6x, that would still represent very strong capital levels for most MPL writers, which suggests that there is more than $7 billion in redundant capital within this group of insurers.

The MPL market’s capital position can be viewed as both a blessing and a curse. Strong capital levels allow MPL specialists to withstand considerable future financial stress that may result from a shift in claims experience or adverse investment-market performance. But, abundant underwriting capacity within an insurance market also promotes price competition and, ultimately, inadequate premium rates.

**MPL specialists’ strategic options**

Strategic options are more limited for the smaller specialty writers that have limited capital market access, but they can be defined broadly as a choice between (1) staying the course, and (2) diversifying, either by business segment or by geographic scope of coverage.

Utilizing specific mono-line underwriting expertise and relationships within a narrower geographic area remains a core primary strategy of most MPL specialists. Greater deterioration in premium volume, combined with a return to significant underwriting losses in MPL, would likely spur significantly more introspection in regard to capital allocation and underwriting mix.

Diversification into new insurance markets can provide opportunities for directing capital into a growth segment and thereby reduce product concentrations. However, product diversification efforts that are marked by poor execution and insufficient underwriting expertise can prove perilous and also consume considerable effort, in both time and management, to unwind. Prior diversification efforts by MPL specialists in the 1990s into long-tail lines and reinsurance proved highly unfruitful.

One specialist has positively altered its business mix in recent
years toward workers compensation and other liability products besides
MPL. However, other market participants may remain reticent about
entering new product markets in light of their limitations in requisite
skill sets.

Mergers and acquisition activity within the MPL space provides
an opportunity to add operating scale and quickly diversify into new
states or new types of healthcare providers. Acquisitions within a
company’s core business still have inherent risks, linked to valuing uncertainty for insurers with long-tail reserve exposures and challenges in realizing integration of the companies and achieving the hoped-for reductions in costs.

MPL market share is less concentrated among the largest writers
of this coverage than it is in other U.S. property/casualty segments, for historical reasons, and MPL has been considered a candidate for consolidation for some time now. Figure 5 sorts PIAA members by size and geographic scale, revealing that a large number of MPL specialists have less than $200 million in premiums and a narrower geographic focus. The size of the bubble represents policyholder surplus, the y-axis shows net written premiums, and the x-axis represents how many states account for greater than 1% of direct premiums.

Acquisition activity in MPL has been muted for the last several years (Table 1). The 2016 announcement that Berkshire Hathaway is purchasing New York’s Medical Liability Mutual Insurance Company, the first- and fourth-ranked MPL underwriters by NWP in 2015, may portend a shift in segment M&A activity.

Consolidation in MPL is still most likely to converge around existing larger market participants than the newer market entrants. Transaction volume is inhibited by a lack of willing sellers. As (typically) mutual or reciprocal insurers, MPL specialists do not face shareholder pressure to boost returns or realize enterprise value through a sale.

There is also greater potential for more creative structures, including partnerships and affiliation agreements between MPL insurers, which may provide cost-sharing benefits and scale, while at the same time, preserve the strength of individual brands—without executing a complete merger. One example: West Virginia-based workers’ compensation writer Brick Street Mutual entered into an affiliation agreement with Ohio-based Motorists Mutual in October 2016.

A key question is whether further significant declines in premium volume, deterioration in profits, or capital erosion will induce more MPL specialists to seek new kinds of business combinations. A minor wave of mergers that culminates in some changes in MPL market composition seems like a stronger possibility as 2017 proceeds.
Providing expertise and resources to support strategic decision making beyond the reinsurance transaction
Diversification in the Medical Professional Liability Market

Adaptability is essential in an ever-changing environment, and a vital element in making the most of the new opportunities that change can make possible. This is the situation now confronting today’s medical professional liability (MPL) insurers.
What’s behind the changes?

MPL insurers are confronting significant challenges in today’s market. The top 15 MPL insurers in 2015 have seen their direct MPL premium writings shrink by approximately 6.0% from 2014. The MPL industry as a whole has realized a decrease in direct premium writings of approximately 2.4% annually during the past five years, and 3.0% annually if measured from the high point of the market, in 2006. Figure 1 illustrates these changes.

In response to this steady decline in written premium, MPL insurers have been looking for ways to bolster their topline revenue. As it becomes increasingly unlikely that this can be achieved through new business acquisition in their current markets, insurers are incorporating practical, and sometimes novel, diversification approaches into their plans. All of the insurers are impacted by the same market forces, but they are deploying different strategies to address them.

As larger physician groups are created and more doctors become direct employees of hospitals, the use of self-insurance, captives, and risk retention groups (RRGs) has increased. Larger physician groups are also using captives and self-insurance to realize cost savings, which is reducing premium from guaranteed-cost policies in the admitted market. For MPL insurers, this has meant a steady deterioration in insured exposures and a corresponding loss in written premium.

MPL insurers respond

Some MPL insurers are responding proactively to these major market shifts. As the claims environment and marketplace have changed, the needs of the physicians served by these insurers have also changed. These changes in services required by insureds have provided an opportunity for insurers to maintain their existing customer relationships, but in capacities other than as primary insurers.

For instance, many larger physician groups are now self-insuring and thus no longer require primary-layer insurance. However, they still require excess-layer coverage. Physician groups utilizing captive insurance often need an admitted carrier to front their business and act as reinsurer on the excess coverage layers. MPL insurers are stepping in to facilitate these arrangements. In addition, while MPL insurers are taking on a smaller portion of the risk, they can still serve their clients’ needs through non-risk-bearing services. They can serve as third-party administrators (TPAs) for claims management, offer underwriting guidance, provide consulting on loss prevention and safety, and take on additional consulting roles to further capitalize on their traditional expertise.

Physician-focused MPL insurers are also pursuing strategies that include providing additional coverages related to their core competencies in order to maintain customer relationships and revenue. For example, these insurers are increasing their premiums from policies that insure allied health professionals. According to data from the Supplement A to Schedule T annual statement, the top 15 MPL insurers of physicians increased their premium writings of allied health professionals by 10.0% in 2015 and 7.6% in 2014. This far outpaced the premium growth of insurers that specialize in insuring only allied health professionals, whose premiums increased by 3.9% and 1.8% over the same time periods, respectively.

MPL insurers are also looking to expand their geographic footprint and lines of insurance offered. Acquisitions have been the primary vehicle for this type of growth, but several companies have also formed or gained control of RRGs to penetrate new markets. The changing healthcare delivery system is driving much of this expansion. As physician groups diversify across state lines, they require insurers that are able to conduct business in those states. Recently, there have also been acquisitions and expansions into other lines of business such as lawyers’ professional liability, workers’ compensation, and product liability. On a group basis, the top 15 MPL writers have seen impressive year-over-year growth in non-MPL written premium since 2011, ranging from 5.0% to 8.0% annually. In contrast, the four years prior to that time had consistent year-over-year declines in non-MPL premium. Figure 2 depicts these changes.

MPL insurers are also offering additional services and coverage add-ons beyond MPL, to address the new risks in the changing healthcare landscape. Some provide captive management services for physician groups looking to form captive insurance companies. Those same groups, which now face expanded business-management responsibilities, frequently require errors and omissions (E&O) coverage in addition to MPL. At the same time, mandates for electronic medical records and Health Insurance Portability and Accountability Act (HIPAA) requirements have led to greater exposure to cyber liability. In response, insurers are crafting policies for their customers that address these new risks.

Rob Walling, MCAS, MAAA, CERA, is a Principal and Consulting Actuary with Pinnacle Actuarial Resources, Inc.
The proof is in the pudding
As insurers trim their sails in response to the changing winds of the MPL market, is any of it working? Are the MPL writers that are adapting and diversifying successfully in fact maintaining their topline revenue better than those that are not?
A survey of the market’s largest participants indicates that the value of their diversification strategies is just one component in their longer-term plan.

The Doctors Company (TDC) has been pursuing an acquisition strategy since 2007, commencing with the purchase of OHIC Insurance Company, an Ohio physicians’ mutual writer. In 2014, TDC became the parent company of Medical Advantage Group, a healthcare consultancy that aims to improve efficiency and integration for healthcare systems and providers. These types of services bolster and expand TDC’s market positioning in this era of ongoing consolidation in healthcare delivery entities, thereby enabling TDC to diversify its products and services beyond insurance and risk management.

TDC offers its larger customers patient safety assessments, risk management of human resources, captive management, risk analytics, and benchmarking services. Coverage options range from large deductibles and self-insured retentions to retrospective rating and profit-sharing programs. The insurer also provides a variety of non-MPL insurance products, such as employment practices liability, E&O for managed care and billings, and directors and officers (D&O) liability.

Individual physicians’ premiums may include administrative and regulatory actions related to HIPAA, state medical boards, national specialty oversight organizations, and cyber liability coverages, and provide for continuing medical education credit opportunities. TDC also has an underwriting program for physicians who do not meet standard underwriting guidelines. This scorecard provides a mechanism for TDC to write a policy for these physicians, adding a surcharge to the premium rather than turn them away. All of these offerings are designed to attract and retain physicians and increase premiums.

ProAssurance Corporation is another large national carrier that has pursued an acquisition campaign for a number of years. Its most notable additions include National Capital Reciprocal Insurance Company (NCRIC) in 2005, Physicians Insurance Company (PIC) of Wisconsin in 2006, PACO Assurance Company, Inc., and Podiatry Insurance Company of America (PICA) in 2009, American Physicians Insurance Company in 2010, and Independent Nevada Doctors in 2012. All of these insurers were MPL writers, but in contrast to TDC, ProAssurance has most recently acquired companies whose primary lines of business are not MPL.

In 2009, ProAssurance acquired Georgia Lawyers Insurance Company, a writer of lawyers’ professional liability (LPL) for attorneys in Georgia that expanded an LPL book already written by ProNational Insurance Company. Then, in 2013, ProAssurance acquired Medmarc Insurance Group, a writer of primarily product liability coverage for medical devices, but with a small book of LPL as well. In 2014, ProAssurance acquired Eastern Alliance Group, which writes workers’ compensation for small- to mid-sized employers on the East Coast and in the Midwest. With the ability to write lines of business beyond professional liability, ProAssurance can service a wider portion of their customers’ risk spectrum.

MedPro Group, the largest MPL insurer in the U.S., is proactively working to not only maintain but also expand their leading market share. In 2009, MedPro Group formed MedPro RRG to primarily service business written in the state of New York. In 2011, MedPro formed another RRG, AttPro RRG, for LPL and also acquired Princeton Insurance Company. In the summer of 2015, MedPro announced its...
acquisition of PLICO, an Oklahoma-based MPL insurer. The most recent action was the announcement of MedPro’s intention to acquire the largest MPL insurer in New York, Medical Liability Mutual Insurance Company (MLMIC). MedPro illustrates again the trend toward geographic expansion through acquisition, but differentiated by the utilization of alternative insurance vehicles.

In 2014, Coverys announced its partnership with Academic Medical Professionals Insurance RRG, a member insurance company of the Academic Group that primarily insures academic medical professionals in New York state. The partnership allows Coverys access to a nationwide network of academic medical professionals, while providing the capital support that the RRG needs for national expansion.

Coverys has also made inroads into the alternative market space in at least two important ways. Most recently, in 2016, Coverys purchased a large minority stake in Strategic Risk Solutions (SRS), a leading captive management firm with significant MPL captive expertise. As health systems and doctors’ groups look to alternative risk financing mechanisms, SRS provides Coverys with a vehicle for servicing its customers with implementation of an alternative risk structure. Similarly, Coverys offers SRS a related company with strong expertise in fronting arrangements, safety and loss control services, and TPA services.

RRGs are not new to the MPL space, but they are increasingly coming under the control of traditional insurers. RRGs are regulated solely by their state of domicile, thus allowing greater ease and flexibility to expand into new markets, particularly in states with onerous regulatory requirements for traditional admitted insurers. Also, compared with admitted carriers, the structure of an RRG makes it easier to tailor coverage to address specific risks. These features can be attractive to insureds whose evolving operations require particular policy features, or who are expanding into new states where their current carrier is not admitted. RRG policyholders are also owners, a concept that many physicians find very appealing: In this structure, they get to manage and underwrite their own risk.

What’s next?
As the winds of change drive MPL premium and exposure from the admitted market, the future of MPL insurers will undoubtedly be influenced by the well-established preference of the medical community for retaining risk and shaping its own risk-control program. What the future market may look like, and when the market will reach a new equilibrium, remains to be seen. But in the interim, the challenge to MPL insurers will be to recognize their customers’ changing needs and provide solutions for them, while at the same time considering whether to expand into complementary lines of insurance.

Whether this trend continues will depend on the existence, and the efficacy, of the types of tools that insurers opt to use in leveraging these changes to their advantage.

Footnote
1. All insurance company financial data in this report is derived from NAIC annual statement data from A.M. Best Company.
KEEPING DOCTORS IN MALPRACTICE.

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The impact of the 1999 Institute of Medicine (IOM) report “To Err Is Human” was regarded by many as the defining moment for the patient safety movement. Anticipation was high that changes that were long overdue for the healthcare industry would accelerate going forward—changes such as widespread process standardization, identification and implementation of key safe practices, and adoption of uniform ways of measuring improvement.

But that has not necessarily been the case. Despite early progress, some experts believe that the patient safety movement peaked within just a few years after the initial IOM report and has yet to accomplish many of its far-reaching goals. Healthcare remains disjointed, the delivery system still has multiple vulnerabilities, and potentially preventable tragedies continue to occur. And, this is despite the entry of electronic health records into the mix—a move that, at one point, was thought to be the cure-all for many of the issues plaguing patient care.

So why hasn’t patient safety taken a stronger hold?
There are many answers to that question, and no one singular theory is probably fully accurate. It is almost certainly a sizable combination of factors that go hand-in-hand with one of the most complex businesses in the U.S., if not the world. How hospitals, practices, and physicians are paid

Robert Hanscom is Vice president, Business Analytics, at Coverys.
is a force unto itself, and is one of several drivers of how care is delivered. But that environment is even more confounded by other factors, most notably, practice-pattern variations that surface by specialty, by institution, and even by individual provider. The lack of uniformity, whether it is in process, cognition, skill, or communication, creates a world so full of variables that it is almost impossible, at times, to reach a core understanding as to why unexpected outcomes are continuing to harm patients.

What exacerbates this struggle is the lack of a single "source of truth"—centralized intelligence that allows those responsible for continuous improvement to obtain a full picture of where the most serious vulnerabilities lie. Historically, this fragmented intelligence has been stored within the following data sets:

- Adverse events
- Root-cause analyses, serious reportable events
- Patient complaints
- Peer-protected reviews (including morbidity and mortality conferences)
- Medical professional liability (MPL) data
- Near-miss data (if collected).

These data sets, each of which has value in itself, are in a different bucket, seen by distinct but not always overlapping groups of people, and they are reported/colllected in differing ways. The result: There is no universal view of anything related to the key safety indicators for healthcare.

All of these data sets are signals telling us where the delivery of care—the processes, the skills, and the decision-making—has been vulnerable in the past, and where that vulnerability may persist. But each segregated data set tells a somewhat different story—if they tell any story at all—and the audience for the lessons learned is decentralized.

Where to start?

MPL activity is often described as the “tip of the iceberg.” Unless the event is a fluke (which is sometimes the case, but not as often some people think), each MPL case should be considered a lagging indicator—and reflector—of where serious problems have existed in the past. Because, for purposes of defense, every MPL case is deeply analyzed, this data can serve as a critical guide as to where these vulnerabilities may continue to haunt the healthcare delivery system.

At Coverys, we are no longer content with simply reporting on MPL trends and then throwing a smattering of risk management content at various topics. We are not alone, by the way: other MPL carriers, captives, and RRGs are on the same march. But data that is presented out of context can quickly fall flat. An important goal with this intelligence is to make it as actionable as possible. To do so, one of the things we are doing is applying this “signal intelligence” to what is familiar and relevant to providers—the processes by which care is delivered.

For example, Figure 1 outlines a set of steps well known to any provider who is prescribing, and then managing, a patient’s medication regimen.

Our risk management codes, displayed at the bottom, are key to capturing and recording the primary causation factors at the root of medication-related claims.

In the case of medication management, Figure 2 shows how the signal intelligence has been applied to these real-life claims. This outlay of data would immediately alert providers to the insight...
that the most vulnerable steps in the medication management process could be found in the process bookends: at the beginning, ordering, and at the end, monitoring and management. That’s not to say that the other vulnerabilities should be ignored. It’s only to suggest that the signals linked with medication ordering and medication monitoring are stronger than those related to dispensing and administration.

As risk is being assessed, the people who are performing the assessment need to be armed with this data. If those steps in particular have stronger signals around vulnerabilities, why? Are those factors still at play in today’s environment? Have the root issues been fixed, or have they been ignored? Is there still a relatively strong likelihood that patients will be harmed because of those unresolved issues?

Similar data displays have been laid out for diagnosis, surgical, and obstetrical claims. Each gives important intelligence to providers as to where the hazards related to any of these categories might lie in the care delivery process, and where potential prioritization ought to be made. But how much more powerful a picture would be created if similar signals were also pulled from other data sources—data sets that, for decades, have been isolated within their own worlds, and never brought into the same centralized view with other data sources?

Consider the power of combined and centralized intelligence coming from a combination of key data sets (Figure 3): But how can a “single source of truth” be created? How can disparate data sets be brought together and used for centralized insight?

The answer lies in the application of a single taxonomy. At Coverys, we have created and finalized a list of codes that cover all known areas of risk and error that most frequently surface as healthcare is being delivered. We have also identified codes for “horizon risk”—risk categories that have not yet materialized as such, but whose indications we are closely watching for.

These codes have been applied to eight years of MPL claims across the Coverys enterprise. The insights, as discussed above, are made available to providers, practices, and hospitals insured by Coverys. MPL is just one of many signals that healthcare should take into consideration. Consequently, this provides us with the opportunity to apply the same risk management codes to other key data sets:

Nothing great is ever achieved without assuming risk.

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adverse events, root cause analyses, serious reportable events, patient complaints, morbidity and mortality and peer review sessions, and near-miss data. A single set of codes will immediately tie these data sets together, allowing a holistic picture of the issues involved and also setting up the universe of data for further analyses.

For example, if the issue is transmission of test results—a factor that has historically been associated with missed and delayed diagnosis—a unified taxonomy would allow a query to tap into data from each of the sources (Figure 4).

Some of the data sets might be “silent,” but, in the example of test results, it is entirely possible that each one will contain activity and will thus be able to contribute to the compilation of actionable centralized intelligence. The same taxonomy brings the data sets together into one body, one language, and one common core, and allows for an understanding of the issue that captures the full depth and breadth of its magnitude throughout the organization.

We are overdue in creating a universe of data that drives healthcare to focus not just on the issues that work their way to the surface (usually through a reactive path) but also on those that represent the greatest threats to the safe delivery of care. Applying analytics and codes to care processes will enlighten providers about precisely where the hazards are; using a common taxonomy for all critical data sets will create an invaluable centralized snapshot of unresolved issues; and ultimately, applying advanced analytics to these data signals will help hospitals, practices, physicians, and other providers to prioritize what fixes need to be made, and, beyond that, to make a coherent case for future investments in safety.

If we don’t act, one thing is certain: The current world of fragmented intelligence will guarantee that improvement will be slow in coming, and care itself will continue to be less than fully reliable.

For related information, see www.coverys.com.
America is facing an epidemic of addiction and overdose deaths. In 2014, there were 47,055 lethal drug overdoses, surpassing automobile accidents as the leading cause of accidental death. Since 2000, lethal drug overdoses increased from 6.2 deaths per 100,000 to 14.7 deaths per 100,000, a 137% increase. The scientific and medical communities have defined addiction as a chronic brain disease that requires chronic management from healthcare providers.

They need to know how to manage addiction as a chronic disease and treat it with medication, along with good interpersonal relations with their patients and reimbursement commensurate with the time they spend on such care.

Addiction is a public health crisis, yet our healthcare system is struggling to contend with the realities of this disease and epidemic. There is a vast treatment gap in the U.S. The 2015 National Survey on Drug Use and Health data indicate that 21.7 million people age 12 or older needed addiction treatment in the past year. However, only an estimated 2.3 million people received treatment at a specialty facility during that time. Just 10.8% of the 21.7 million people who needed addiction treatment in the past year received it, while 89.2%, or 19.3 million people, received no treatment.

The addiction-treatment gap becomes even more evident in looking specifically at opioid addiction and overdoses. Of the 47,055 lethal drug overdoses in 2014, more than 60% of those deaths were caused by opioid analgesics (18,893) and heroin (10,574). In 2003, an estimated 1.5 million people age 12 or older met criteria for opioid addiction; by 2012, this number had increased to more than 2.3 million people. While these numbers can be disheartening for those who work in healthcare, the good news is that there are effective treatment options available that can help patients enter long-term recovery.

**Effective treatments**

Treatment including medications, such as methadone, buprenorphine, or extended-release injectable naltrexone, is the most effective remedy for addiction involving opioid use. Evidence shows that it increases treat-
Similar insurance barriers and lack of provider availability limit access to treatment programs (OTPs) increased annually from 2003 to 2012, from 227,033 to 311,718 patients.3

Unfortunately, many people with opioid addiction still have difficulty accessing treatment. Significant barriers to methadone treatment include waiting lists for entry into treatment, limited geographic and insurance coverage, and the requirement that many patients must physically receive methadone at the OTP daily. Similarly, there are barriers to accessing buprenorphine treatment, such as provider availability and willingness to prescribe, limited insurance coverage, and cost. In 2012, approximately 914,000 people struggling with opioid misuse or dependence in the past year were not able to access care due to the difference between combined methadone and buprenorphine treatment capacity and the number of people with opioid misuse or dependence.3 Similar insurance barriers and lack of provider availability limit access to extended-release injectable naltrexone.

Despite the recent increase in treatment capacity, the documented persistent treatment gap illustrates the shortage of healthcare providers who are educated to treat addiction or who specialize in addiction medicine. The treatment gap can be attributed to the stigma associated with the disease; the result is that services for addiction treatment are delivered separately from other mental health and general healthcare services. Coincidentally, insurers cut reimbursement rates for addiction providers in the 1990s, forcing some physicians interested in the field to return to primary care. Thus, providers who have specialized in addiction medicine and made a career in the field are often required to work from outside the mainstream healthcare system.

### ASAM certification

The American Society of Addiction Medicine (ASAM) was the first national certifying body for specialization in addiction medicine, offering its first exam in 1986. ASAM continued to offer this certification until 2008, when the American Board of Addiction Medicine (ABAM) was established, with the goal of making addiction medicine a recognized subspecialty by the American Board of Medical Specialties (ABMS), as ABMS had already recognized addiction psychiatry in 1991. ABAM achieved its goal in 2016, when ABMS recognized addiction medicine as a subspecialty under the American Board of Preventive Medicine (ABPM). As of November 9, there are currently 3,407 U.S. physicians certified by ABAM, but only 1,088 physicians with an addiction psychiatry subspecialty certification from the American Board of Psychiatry and Neurology (ABPN), and seven physicians with a subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA).

ABMS recognition of addiction medicine is a big step forward in bringing addiction treatment to mainstream medicine and expanding the field’s workforce to meet the high demand for treatment. Importantly, addiction medicine’s official recognition as a “multi-specialty” subspecialty captures the breadth of primary specialties from whence addiction medicine specialists come. Many specialists enter

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**Doctor Beware: Plaintiff’s Attorneys Trolling for Opioid Victims**

**The Internet has numerous sites where law firms are eager to locate alleged victims of physician mistreatment. Here is an excerpt of the typical pitch:**

*Patients Injured by Opioid Painkiller May Qualify for a Lawsuit*

If you or a loved one have been the victim of an overdose or other serious complications caused by opioid overprescription, you may be eligible to file a lawsuit against the doctor or hospital that was responsible for your injuries.

**Although strong opioid painkillers are frequently prescribed by pain specialists with experience in administering these drugs to patients, general practitioners and other doctors with little to no training in administering the strongest painkillers routinely give these drugs to their patients. Studies have found that most doctors who are not pain specialists have trouble administering a correct dose of painkillers to their patients. When these errors result in overdose or death, the doctor or hospital may be at fault.**

The lawyers at our firm are among the nation’s leaders in handling cases involving potent opioids, and we have the experience to prosecute medical malpractice cases involving a wide array of serious opioid painkillers, including Vicodin and hydrocodone, OxyContin and oxycodone, methadone, hydromorphone, Fentanyl, and others.

To receive a free legal consultation and find out if you are eligible to file a case, please call our toll-free hotline, or fill out our free case evaluation form.

www.hop-law.com/opioid-painkillers/
the field after encountering addiction in their primary care patients, struggling with addiction themselves, or seeing a family member or friend wrestle with the disease. ASAM’s membership illustrates this diversity: 33.6% of physicians certified in addiction medicine or addiction psychiatry report psychiatry as their primary specialty, 19.2% report addiction medicine as their primary specialty, 18.5% report family medicine, and 12% report internal medicine as their primary specialty. The remainder represents a mix of other specialties that range from pediatrics to emergency medicine.

The breakdown of ASAM records shows that physicians certified in addiction medicine or addiction psychiatry come from a variety of primary specialties. These physicians also spend varying amounts of practice time caring for patients with addiction; some may treat addiction full time, while others see a few patients with the disease as part of a larger primary care patient load. Table 1 shows the percentage of practice time that certified physicians devote to addiction treatment.

Indeed, there are thousands of physicians who hold board certification in addiction medicine and addiction psychiatry. However, most of them do not have addiction medicine or addiction psychiatry as their primary specialty and do not focus most of their practice on addiction treatment. To make progress toward closing the addiction treatment gap, it will be critical to harness the entire available specialty workforce, regardless of primary specialty or practice focus. Of course, it will also be crucial to incorporate addiction training into medical school and other health professional school curricula, since there will never be enough specialists to care for all patients who need treatment.

All hands on deck
The addiction treatment gap, made evident and exacerbated by the intensifying opioid overdose epidemic, must be addressed by the healthcare system with an all-hands-on-deck approach. While improvements have been made recently, from the recognition of addiction medicine to the federal buprenorphine patient-limit increase from 100 to 275—primarily for addiction specialists—there is still much more that can be done. The entire medical community, from providers to insurance carriers, must come together to find the best ways to increase patient access to the care and treatment they need, as well as assist practitioners who currently work in the field of addiction medicine or are looking to enter it. By working together, we can strengthen not only the addiction medicine workforce, but also the entire healthcare system to bring an end to this epidemic.

References
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  - Cultural competence
  - Managing difficult patient relationships
  - Disruptive physician behavior
  - Documentation
  - Failure to diagnose
  - Medical and surgical system failures
  - Avoiding “never” events
  - Informed consent
  - Low health literacy
  - Common missed diagnoses and errors

- And many more!

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chris@medrisk.com
‘Change & Disruption: Strategies for Managing the Evolution of Medical Liability’

On October 4–6, 2017, the PIAA International Conference—“Change & Disruption: Strategies for Managing the Evolution of Medical Liability”—will be held in London. It will provide a forum for colleagues from all over the world to network and learn the latest from international experts—and from each other. Topics to be presented include the changing medical market and its impact on liability; economics and market disruption; patient safety; emerging risks; and much more.
have an impact on professional liability in the future.

**IML: Where in London is it being held?**

**Tomkins:** We’re right in the heart of London, in a fantastic location next to St. Paul’s Cathedral, with a view over the river Thames. The Tate Modern art gallery is within a few minutes’ walk over the Millennium Bridge, as is Shakespeare’s Globe Theatre.

**Kayll:** The central location provides attendees and their families with great opportunities to soak up the iconic sights of London. We’re particularly looking forward to the gala event at St. Paul’s Cathedral that will be held on the Thursday evening, where guests will be treated to the famous St. Paul’s choir and an organ recital.

**IML: What are some of the topics and themes for the conference?**

**Tomkins:** We’ll cover a wide range of issues impinging on medical liability worldwide, including the economics of change in the medical market, transformation of the medical team, the impact of new technologies, cyber liability and security, big data and clinical coding, patient safety, emerging risks and how to mitigate them, and commercial themes that focus on investment strategies, reinsurance, and underwriting. You don’t have to be directly involved as a company providing medical professional indemnity to get a lot out of attendance at the conference. There is abundant content in this meeting for everyone who is a part of the medical professional indemnity industry, for example, those involved with the legal process, with investment management, data analysis, patient safety, insurance, reinsurance, and so on.

**IML: Can you tell us about some of the conference speakers?**

**Tomkins:** We’ve got some excellent speakers lined up, who will give us the benefit of their wisdom. They’re all experts in their particular fields. For example, I’m looking forward to hearing the talk from Dr. Maryanne Mariyasevann, who’s done some very interesting work on building safety designs into healthcare systems to minimize risk and error. She’ll examine how innovations can help reduce error from known risks.

**Kayll:** It’s difficult to single out just a few of the speakers, because the conference benefits from the vast expertise of all the participants, coming from every corner of the globe. But I’m particularly looking forward to hearing Dr. Jim Bagian (of the Center for Healthcare Engineering and Patient Safety at the University of Michigan) discuss how technology is changing healthcare, Jeffrey F. Driver (from The Risk Authority in Stanford) speak on how patient expectations are evolving, and Dr. Luke Sato (CRICO/Risk Management Foundation of the Harvard Medical Institutions, and Harvard Medical School) present how healthcare professionals can learn from mistakes. There will also be some insightful panel discussions where attendees will have the opportunity to get involved and ask questions.

**IML: Why should PIAA members attend this conference?**

**Tomkins:** It will be a “not to be missed” opportunity for delegates to meet their international peers in the medical professional liability community, to broaden their professional networks, and to learn from each other. We will be exploring and addressing the problems we all face in the medical liability world, and looking at the different approaches we take to tackling these problems worldwide. By coming together, we can discuss common themes and share ideas to expand the scope of success all across our international community.

We have also chosen the timing carefully to coincide with the period when we expect many attendees will be renewing their reinsurance arrangements. Since London is a reinsurance hub, we hope people coming to our conference can take advantage of that to conduct their reinsurance business while they’re here. I think the U.S. term would be a “twofer”!

**IML: How can people sign up?**

**Kayll:** It’s easy! Just visit the PIAA website at http://piaa2017.com for more information and full details on how to register.

It really will be an exceptional opportunity for anyone with an interest in medical professional liability to hear from experts with global perspectives, network, and share insights into the day-to-day issues and developments. We hope that attendees will be able to take away practical and relevant ideas that can be implemented in everyday practice, to make a difference for providers and patients, and improve their country’s rapidly changing healthcare systems.

Chris and I are both looking forward to seeing you here in London in October. **PIAA**

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**Editor’s Note:** Look for the latest information on the conference in subsequent e-mails from PIAA and also plan to visit the PIAA International Conference 2017 exhibit booth at the 2017 Medical Liability Conference in May in Colorado.
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Interview with... Robert M. Wachter, MD

Robert M. Wachter, MD, Professor and Chairman, Department of Medicine of the University of California, San Francisco, is an internationally acclaimed leader in healthcare safety, quality, policy, and IT. Dr. Wachter, who is the Holly Smith Distinguished Professor and the Marc and Lynne Benioff Endowed Chair in Hospital Medicine, was the physician who first coined the term “hospitalist” in 1996, and he is generally regarded as the “father” of the hospitalist field, the fastest-growing specialty in the history of modern medicine. He was named by Modern Healthcare as one of the 50 most influential physician executives in the U.S. for 2016 (number four in 2016, and number one in 2015) and also as one of the 100 most influential people in healthcare.

Dr. Wachter will be the keynote speaker at the 2017 PIAA Medical Liability Conference May 17–19 at The Broadmoor in Colorado Springs, Colorado. Inside Medical Liability caught up with Dr. Wachter to get his thoughts on the current environment for healthcare professionals and MPL/HPL insurers as a prelude to his presentation in May.

Inside Medical Liability: You coined the term “hospitalist” back in 1996. Since then, the field has expanded dramatically. Do you think there is room for even more growth in the ranks of hospitalists, and in what areas or subspecialties do you see that expansion most likely to happen?

Wachter: I don’t think the growth is going to be as great or rapid as in the past, because we have mostly saturated America’s hospitals. There are very few hospitals, except the very small ones, that don’t have hospitalists now. Growth will also be tempered by the shrinking number of hospitals, and hospital beds, over time.

That said, I think the pressure to deliver higher-quality, safer, and less expensive care is going to catalyze continued growth in hospitalists. I think hospitalists will also continue to expand their scope of practice. I think we’ll see more co-management of surgical patients. They will also become increasingly involved in quality improvement and patient safety. As hospitalists assume these leadership roles, they usually decrease their clinical time, so others will need to step in and provide the clinical work.

IML: Well, what about value-based care—will the emerging emphasis on that support the expansion of hospitalists?

Wachter: I think it will cut both ways. For the hospitals, I think it increases the amount of pressure to organize their program so that it delivers high-quality, safe, and satisfying care at the lowest cost. Today’s research says that to do that well, you need to have a hospitalist program. So the value pressure should drive continued growth for hospitalists providing clinical care. It also drives more need for individuals with the time and the skills to develop improvement programs and cost reduction programs. There are many hospitalists who, rather than practicing 100% time, are now assuming roles like chief quality officer, patient safety officer, or chief medical information officer.

The countervailing force is value-based purchasing, which hands the risk of the cost of care to the delivery organization. That will lead to increasing pressure to care for patients in the least expensive possible place. There are patients who today are in hospitals who could probably be cared for safely in skilled nursing facilities or post-acute settings. And there are probably patients in hospitals whose admission could maybe have been prevented if they had better preventive care—or had access to home monitoring with sensors or other kinds of apps.

I think value-based purchasing will drive more innovation and lead to more activities around prevention. This will, I hope, shrink the number of patients who actually have to come into the hospital.

IML: Patient safety efforts today appear to be...
somewhat fragmented. For example, individuals choosing various aspects of it, and doing studies that appear in both conferences and in the scientific literature, seem to be in relative isolation from each other. Is that true? And if it is, what can be done to improve coordination among the many disciplines involved?

Wachter: It depends on the organization. As I look at our program here, it’s reasonably coherent. There is central management of quality, a patient safety officer, and a team that is charged with figuring out the key issues we need to be focusing on, institution-wide.

The fragmentation comes in part of necessity, because the patient safety issues for ob-gyn are pretty different from the ones for the OR, and different from the ones on the medical wards.

But you do have a little bit of an “initiative of the month” problem, where this week we’re focusing on preventing falls, and the next week we’re focusing on checklists in the OR; then the week after that, we’re focusing on improving our culture. Patient safety is still a relatively young field, and it’s really hard, so you do one thing, and then some research comes out and says, try something different. And so you do.

Another issue is computerization, which is relatively new in most healthcare organizations. Computerization would ideally be a force for cohesion, sharing best practices, and hard-wiring best practices. Right now, that isn’t the case in most places. In fact, computerization has solved some patient safety problems, but it’s also created a whole new crop of other issues that none of us were really ready for. Now we’re working on trying to figure out how to mitigate them.

IML: But all of it is being compiled in the medical literature, right?

Wachter: Yes, we kind of learn as we go along, but it’s a challenge. If a study shows that drug A is a better treatment for meningitis than drug B, whether you have a 50-bed rural hospital or a 600-bed academic medical center doesn’t make that much difference as to your decision on which drug to use. Whereas, how you deal with hand-off errors, how you improve culture, how you improve teamwork—those have very different flavors from one place to another, even if you look at the literature and they say, this kind of checklist works really well here. If “here” is very different from your facility—has a different culture and different leadership—it may not translate that well.

Improving safety and quality is more subtle, more nuanced, and more local than traditional clinical research, where you might read something in the literature and say “okay, that’s a better way of treating a heart attack.”
IML: Can anything be done to discredit and stop the generation of ever-higher estimates on numbers of patients injured by adverse events in medical care?

Wachter: Yes—we could stop publishing them. Some of them are not very scientific. The latest one, the 300,000 estimate that came out, I thought was actually a fairly bad study. The science was not supportable. I was quite surprised that the British Medical Journal chose to publish it. Not only did they publish it; the press got ahold of it and went wild. There’s no new data there at all. The press got excited about the idea that maybe it’s not 100,000 people a year dying, it’s 300,000.

IML: In BMJ Quality & Safety (February 18, 2016), you and your coauthors write that, “We believe its [hospital mortality] use, while well intentioned and with some value, is too problematic to merit inclusion in pay-for-performance programmes.” Do you still think that’s a reasonable statement?

Wachter: Yes, at this point the science of measuring mortality and making sure you’re sufficiently adjusting for the predictors of mortality that have had nothing to do with medical care is not sufficiently advanced to use mortality rates to change payment. I have no problem with gathering and disseminating these rates. But public reporting has a version of the same problem. If it’s bad data and insufficiently adjusted for co-morbidities, it’s confusing and will cause people to make bad judgments.

IML: In 2014, you said that leaders must address individuals who choose to disregard established safety rules. Do you still favor that position—a greater emphasis on individual accountability as opposed to systems?

Wachter: It’s not as dichotomous as that. I think we’ve gone through a series of stages of patient safety. When I grew up and trained, we were massively underweighting the importance of systems. And even that is an understatement: we never even thought about systems. We learned nothing about systems, about culture or standardization. There was nothing about the science of quality improvement. It was not on the radar screen of the training of a physician, nor of most healthcare administrators.

This, coupled with the malpractice system, led to massive over weighting of the role of the individual and underweighting of the role of the system. I think that the emergence of the patient safety field led to a much needed correction, with an emphasis on the idea that the system is always important and, more often than not, determinant.

And when you drill down into most errors, what you find is that these were good people trying to do the right thing, operating in a dysfunctional system. So if you want to prevent errors, you’d better make the system better. All of that is very healthy.

My concern is that now we have a tendency to call everything a systems problem.

Computerization has solved some patient safety problems, but it’s also created a whole new crop of other issues that none of us were really ready for. Now we’re working on trying to figure out how to mitigate them.

There are things that are not—or not as much as we characterize them. Most diagnostic errors are still individual faults, although one could envision a system that would be helpful, but we haven’t invented it. It’s going to take advanced artificial intelligence and computer systems that are not there yet.

IML: What new or specific roles do you see for medical and healthcare professional liability insurers in the evolving healthcare paradigm?

Wachter: Well, I’m not sure. Based on the U.S. election in November, the paradigm is going to evolve some more. But the prospects for massive changes in the liability climate and the rules seem quite small. They never seem to change very much, independent of what color the administration is that comes in.

I think that where liability carriers have played a very important role in the last several years—probably earlier than much of the rest of medicine—is in appreciating the importance of system thinking. They have supplied the cases and data that help us understand safety hazards and potential fixes of them.

IML: Overall, are you, personally, optimistic about the future of healthcare in the U.S.?

Wachter: There is a lot of hype about transformation of healthcare. Today, there are still diabetics measuring their sugar, writing it down, and then seeing their doctor every three to four months to talk about how it all went. The endocrinologist then tells them about how they should change their medicines, and then they go home and do some stuff, and maybe get it right or wrong.

That’s ludicrous of course. There are apps that let diabetics measure their sugar, digitally, and then the measurements go into a device that triggers an algorithm that says, “It looks like your sugar is a little high; maybe you should increase your insulin.” And the data are also getting streamed to a dashboard that’s being followed by either a doctor or a health coach who is watching how a bunch of patients are doing. And he will intervene when needed.

That’s a nice model—but will it fundamentally change the nature of the healthcare system? Probably not. It’s basically just a better way of doing what we’re already doing.

Where my “hype meter” goes off is when I hear about patients wearing an Apple watch, and it’s measuring their blood pressure and their heart rate variations every minute. And that data is being sent to their doctor, who (the story goes) is happy to receive that data, along with that of 1,199 patients, in her panel. That is a planet that I’m not familiar with. The fact that we can monitor all this information doesn’t make that endeavor worthwhile. This is in contrast to the data from the diabetic, which is valuable.

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Trump was initially feared to be a bull in a china shop who would wreak havoc on the global economy with his protectionist policies and punitive tariffs. However, his behavior since the election has engendered optimism that the more disruptive policies that he touted on the campaign trail will evolve into more measured and productive fiscal stimulus. To better understand the logic behind the market’s reaction, we should first examine what we know so far about the proposed changes.

The key elements of Trump’s fiscal policies are (1) a large increase in infrastructure spending and (2) tax reform measures aimed at lowering both personal and corporate rates. He has also proposed a foreign profit tax repatriation holiday, which would allow multinational companies to move the vast hordes of cash they now hold abroad back to the U.S. at a substantially lower tax rate.

Other proposed actions include rolling back recent regulations, with a particular focus on making life easier for companies in the energy and banking sectors, and a more active approach to protectionism that seems to involve direct presidential communication and the threat of large tariffs to prevent the outsourcing of jobs.

How much inflation?
While it is difficult to predict how many of these policies will actually be implemented, one common theme that runs through the proposals is their inflationary bias. A large injection of fiscal stimulus in the form of lower taxes and infrastructure spending could drive inflation higher, particularly in an economy that has now reached full employment.

Tariffs are another potential source of inflation. President-elect Trump had specifically mentioned imposing tariffs on imports from China and Mexico, which could greatly increase the cost of many consumer goods. According to Goldman Sachs, a 10% increase in U.S. tariffs would, on average, add 0.6pp to the level of the core personal consumer expenditures (PCE) index.

One potential offsetting force is the strength of the dollar. With U.S. interest rates moving higher and the Fed committed to tightening policy, the greenback has rallied over the past month. While this hurts domestic exporters, whose goods are made less competitive by the stronger dollar, it helps importers, who can now buy more for each dollar spent. Since the U.S. is a net importer of goods, the primary result of a stronger dollar is lower import prices, which exerts downward pressure on inflation.

The market’s reaction to Trump’s proposals has been decisively inflationary. Inflation break-even expectations, as measured by the difference in yield between 10 year Treasury bonds and 10 year Treasury Inflation Protected Securities (TIPS) bonds, are up from a low of 1.20% in February 2016 to 1.98%, with 30 bps of this increase coming since the election (Figure 1). TIPS have benefitted from this, as many investors now view them as the risk-free asset class of choice.

Another area of the fixed-income market that has been significantly impacted by Trump’s proposals is tax-exempt municipals. With major cuts to both corporate and per-
sonal tax rates looming on the horizon, the traditional benefit of tax-free income that municipals offer appears less valuable. Investors have begun to vote with their feet, moving approximately $5 billion out of municipal funds during the month of November and pushing yields in the space higher.

A Brave New World
While the exact details of President Trump’s policies remain a mystery, it has become clear that the economy has embarked on a new journey. From the U.S. to Europe to Japan, policymakers have seen the unintended negative consequences that low and/or negative interest-rate policies can have on the broader economy. Asset classes that have benefitted from the unprecedented levels of global monetary stimulus will begin to suffer as liquidity is slowly withdrawn. The rise of populism and protectionism has caused many to re-evaluate the benefits of open borders and global free trade. Discussions about inflation have shifted from the threat of deflation and persistently low levels of inflation to concerns about runaway inflation driven by deficit spending and a tight labor market.

We are entering into a new policy regime, where the responsibility for stimulating demand appears to be shifting from the central banks to the fiscal authorities. A smooth handoff could successfully reduce the risk of large-scale asset bubbles and would also serve to jolt global growth into high gear. However, there are plenty of risks on the horizon, not the least of which is the potential for a global trade war triggered by the U.S. and China. While much remains to be seen, the balance of risks has clearly shifted in favor of higher inflation and interest rates.
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ARE WE AFRAID TO TAKE CASES TO TRIAL?

BY JOHN E. HALL, JR., AND LAUREN SPEARS

Five Common Myths about Medical Professional Liability Trials, and Why More Cases Should Be Tried

Few things strike more fear into medical professional liability (MPL) insurers than the prospect of taking an MPL claim to trial. It seems that media coverage constantly tells us about multi-million-dollar jury awards to plaintiff patients; but this perception is not really accurate. According to PIAA, insurers prevail in 91% of the medical negligence claims that ended with a verdict between 2003 and 2012. Yet, only 8% of claims make it to the verdict stage of trial.

Myth 1. Juries are sympathetic to plaintiffs, to the detriment of defendants.

Insurers and defendant physicians may be hesitant to take an MPL case to trial; they’re worried that jurors will be swayed by a sympathetic, injured plaintiff and see the defendant physician or hospital as an evildoer with deep pockets. However, data from empirical research contradicts this idea.

One study by the U.S. Bureau of Justice Statistics estimated that, in 2001, there were more than 1,100 MPL cases tried before juries in the 75 largest counties in the U.S. Of these jury trials, plaintiffs won in only 27% of cases. Research also suggests that physicians win 80%–90% of jury trials with weak evidence of negligence, about 70% of cases with neither strong evidence of negligence nor strong evidence of non-negligence, and 50% of cases where there is strong evidence of medical negligence.

These figures indicate that juries do not make their decisions based solely on their emotional attachment to an injured plaintiff. Furthermore, the evidence does not support the idea that jurors render verdicts for plaintiffs and against doctors or hospitals simply because they are assuming that the doctor or hospital has the “deep pockets” needed to pay the awards. In a study conducted by Vidmar, 147 people called for jury duty were asked to award damages for pain and suffering in a case where the plaintiff suffered a broken leg as a result of complications. For one set of jurors, the cause cited was medical negligence, but for the other jurors, the fracture was attributed to a car accident. When the awards from each set of jurors were compared, there was no statistically significant difference.

Myth 2. Juries do not understand the science.

One common criticism of juries is that, because they are made up of laymen, their members are not always sophisticated enough to understand the science presented by medical experts in MPL cases. However, multiple studies have revealed data that contradict this view.

A study by Taragin et al. used data from the closed-claim files of an MPL insurer. Medical doctors examined these files and documented their opinions as to whether or not negligence had occurred. These opinions were then compared to what juries had determined...
when the cases came to trial. In these cases, jury verdicts were highly consistent with medical judgments and were not related to the severity of the injury suffered by the plaintiff.7

Further, research suggests that juries do not simply listen to expert witnesses and blindly follow their guidance. Results of an Arizona Jury Study Project study revealed that jurors ask incredibly thoughtful and intelligent questions of expert witnesses and that they are vigorous in their deliberations. Overall, “juries are anything but passive participants who simply defer to experts or just superficially gloss over the standard of care.”

These studies tend to disprove the myth that juries will blindly follow whatever an expert witness says at trial, or that juries are incapable of understanding the complex information presented during the course of an MPL trial.

Myth 3. Jury awards are unpredictable.

Another reason why insurers and defendant doctors may choose to settle a case, rather than take it to trial, is the assumption that juries are unpredictable. When entering into a settlement, defendants likely take comfort from the fact that they know exactly how much they will have to pay, rather than rolling the dice and possibly having to pay out much more as a result of a jury trial. However, research suggests that jury awards are actually quite predictable, and that defense attorneys are the best at predicting what those awards will be.

Just as jury verdicts tend to be consistent with medical judgment, similarly, they are also highly consistent with the opinions of judges. Some studies have asked judges to make independent decisions about liability prior to learning how the jury decided. The findings from these studies revealed that there is a high degree of agreement between judges and juries on liability and, even when the judge disagreed with the jury decision, the judge usually noted that there was evidence suggesting that a reasonable jury could just as well have decided for the other party.

Furthermore, damage awards tend to correlate with severity of the injury. A study by Bovbjert et al. found that the magnitude of jury awards in MPL cases positively corresponds to the severity of the plaintiff’s injuries, with the exception that awards for injuries resulting in death were usually lower than awards for plaintiffs with severe and permanent injuries.7 Several other studies have found similar results, and there is no evidence that these jury verdicts resulted from anything other than the evidence presented at trial, such as sympathy for the plaintiff among jury members.10

Research also suggests that the defense counsel, as compared with the plaintiff’s counsel or medical experts, is better able to predict whether any payment will be paid to the plaintiff by a physician, whether through settlement or as a result of a jury trial.19

Myth 4. Taking a claim to trial costs more than settling.
The myths about MPL trials are not limited solely to issues with juries, though. When it comes down to the dollars and cents of taking a claim to trial versus settling with a plaintiff, a common perception is that it will always cost more to take a 50-50 claim to trial than to settle right at the outset. This, too, is a myth.

Data from PIAA’s Data Sharing Project, of claims closed between 2008 and 2012, show that the average allocated loss adjustment expense (ALAE) was higher for claims that ended with a verdict instead of a settlement.13 In one study, researchers examined 465 claims from a single hospital, 242 of which resulted in lawsuits.13 They coded incidents based on salient characteristics, such as severity of injury and quality of care, and then cataloged the final dispositions, including the settlement or verdict awards.13 Although the sample produced only a few plaintiffs’ verdicts, the awards in those cases were generally comparable to the settlements in other cases with similar characteristics.9

Other data suggest that big awards often attributed (incorrectly) to jury verdicts are more commonly a product of settlement. In a study of Florida closed MPL claims between 1990 and 2004, researchers found that the vast majority of payments of more than $1 million were the product of a settlement, not a jury verdict.9 Of 801 cases with payments of more than $1 million, 747 cases were resolved before jury verdict.9 Even more notable, of the 801 cases with awards of more than $1 million, only 34 involved “mega-awards” exceeding $5 million.21 Of those 34 cases, two were decided by a jury.22 So, even if a jury returns an outlier award, there...
is reason to believe that the award will ultimately be mitigated after the gavel falls.

The caveats
Of course, there are some caveats to the idea that more MPL cases should be taken to trial. First among these is the fact that it takes longer to resolve a claim when it is taken to trial. Time is money, and the monetary (and intangible) costs of resolution grow when the resolution time of a claim is almost doubled by taking it to trial. However, it would seem that the monetary cost is already taken into account in the foregoing analysis, which recognizes significant increases in ALAE for claims resolved at trial. Still, there are certainly intangible and business costs associated with maintaining ongoing litigation without certainty of what the eventual exposure will be for the insurer.

Another premise here is that the percentage of successes in these cases will remain the same when more cases are taken to trial. This proposition is shaky, particularly since the additional claims that would be taken to trial are likely to be the less favorable cases for the insurer, with greater likelihood of an adverse verdict. But even if this is the case, it is unlikely that a change in the rate of success in jury trials will be sufficiently significant to alter the overall conclusion.

So, multiple empirical studies indicate that fear of taking a case to trial based on common myths is not supported by the results of these studies. Trial should not be avoided simply because of fear engendered by myth.

References
2. Id. at 368.
4. Id. at 371.
5. Id.
6. Id.
7. Id.
9. Id. at 371.
10. Id.
13. Id.
14. Id. at 137.
17. Id. at 787.
18. Id. at 802-03.
19. Vidmar, 368.
20. Id.
21. Id.
22. Id.
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Finding new ways to improve patient care and, at the same time, minimize medical liability exposures—and lawsuits—is a never-ending quest for healthcare professionals and medical and healthcare professional liability (MPL/HPL) insurers. Over the years, many innovative solutions have been tested in an effort to actualize this goal.

Hospitals, too, have dedicated substantial time and resources to the enhancement of patient care. And now, one health system in Louisiana is taking a radically novel approach, setting the highest possible standard for sustaining quality while at the same time controlling costs—they’re offering a warranty to patients.

If you think this sounds like something an appliance manufacturer or automobile dealer would propose, you’re right—it is. Our Lady of the Lake Regional Medical Center, a facility in the Franciscan Missionaries of Our Lady Health System, is the state’s first hospital to offer a guarantee to every patient receiving a hip or knee replacement. Here’s how the warranty works: The hospital is not charging for any additional care that is provided within 30 days of either procedure, and it will cover the costs for everything—readmissions, infections, rehabilitation, and postoperative care—the only exception being malfunctions in the implant devices.

What are the benefits? According to CEO Scott Wester, one benefit of the facility’s unique approach is to “help the hospital meet the patients’ best interests and reduce variations of care and variations of outliers.” There is also the additional goal of lowering expenses.

Wester said that Our Lady hopes to “address the overall cost of care by eliminating the need for post-surgical follow-up care or not charging for this care in the rare instance it is necessary.”

This twist on warranties may bring a whole new meaning to the term “consumerism” as it’s used in healthcare. In any event, the next time you’re shopping for a washing machine, and the salesperson starts to tell you about the fabulous warranty, you may find yourself thinking about this age-old concept in a whole new way.

Could this catch on? Clearly, Our Lady has abiding faith (excuse the spiritual pun) in its surgeons, nurses, and the other members of its clinical team in order to make this offer in the first place. But it is questionable if other hospitals would be willing to put this sort of “skin in the game” and assume the financial and other associated risks implicit in this sort of arrangement.

And what about the patient—does he play a role in the success of this plan? He must, I believe, or it won’t work. Our Lady seems to have thought this through: In their model for care, each patient is asked to be “an active participant” in care and recovery, and agree to attend preoperative classes and evaluations.

And, maybe most important for PIAA members, what are the potential ramifications for MPL/HPL? As I see it, this type of arrangement would only serve to enhance communications between the healthcare professional and the patient; that could (potentially) lead to a reduction in claims.

By addressing post-operative and other related issues quickly, and at no cost, this approach would seem to help reduce the specter of litigation—always looming whenever there is a treatment complication or unanticipated outcome after a medical procedure.

Time will tell, but this twist on warranties may bring a whole new meaning to the term “consumerism” as it’s used in healthcare. In any event, you’re shopping for a washing machine, and the salesperson starts to tell you about the fabulous warranty, you may find yourself thinking about this age-old concept in a whole new way.
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